REMARKS

Overview

Claims 1-4 and 9-11 are pending in this application. Claims 1 and 9 have been amended. The present response is an earnest effort to place all claims in proper form for immediate allowance. Reconsideration and passage to issuance is therefore respectfully requested.

Issues under 35 U.S.C. § 101

Claims 1 and 9 have been rejected under 35 U.S.C. § 101 because the Examiner indicates that the claims fail to provide a tangible result and thus are directed to non-statutory subject matter. The Examiner articulates that claims 1 and 9 have no result tied to the physical world. Claims 1 and 9 have been amended to include "providing an output from the computer indicative of the virtual health care network." Providing an output is a concrete tangible result tied to the physical world. Support for this amendment is clear at least from the original specification, page 12, line 20 to page 13, line 3 indicating the use of the computer to generate reports. Thus, it is respectfully submitted that this rejection be withdrawn.

As claims 2-4 and 10-11 depend on claims 1 and 9, it is respectfully submitted that these rejections be withdrawn as well.

Issues under 35 U.S.C. § 112

Claims 1-4 and 9-11 have been rejected under 35 U.S.C. § 112 as failing to comply with the written description requirement. In particular, Examiner identifies that a written description was not provided for the added claim 1 limitation of "selecting one or more healthcare networks for each state based on the measures of network utilization to provide a subset of healthcare

networks for each state" and the claim 9 limitations of "identifying a subset of the networks of the networks with the highest utilization, the subset of networks less than the total number of networks", "for each of the subset of the networks." Claim 1 has been amended. The original specification also supports the above limitations in that "those PPOs with the highest utilization are thus selected for a cost saving analysis." (Specifications, Page 11, Lines 4-5). The selection of only those provider networks with the highest utilization will naturally create a subset or reduced set which has a lesser number of networks than the original system of networks because at least the network with the lowest utilization will not be selected for further evaluation. Therefore, these limitations are supported within the original specification, and it is respectfully requested that the rejections be withdrawn.

The Examiner also identifies that a written description was not provided for the claim 1 limitation of "selecting one or more healthcare networks per state having the highest projected savings from the subset of the healthcare networks for each state, the selected one or more of the healthcare networks per state forming a smaller set that the subset of healthcare networks." Claim 1 has been amended. The original specification encompasses a method which includes "comparing the utilizations for different networks, projecting future saving for networks have the highest utilization, and selecting the networks with the greatest savings." (Specification, Pages 5 Line 21 through Page 6 Line 2). Because the specification requires the selection of networks with the greatest savings, at least the networks with the least amount of savings will not be selected, thus creating a reduced set with less networks that the previous subset. Therefore, it is respectfully requested that this rejection be withdrawn.

As claims 2-4 depend from claim 1 and claims 10-11 depend from claim 9, these rejections should also be withdrawn.

Claims 1-4 have been rejected under 35 U.S.C. § 112 as failing to comply with the enablement requirement. Specifically, the Examiner finds that the specification does not provide any specific calculations or computations to find the number of participants who utilize a healthcare provider in the network, the percentage of participants who utilize a healthcare provider in the network, a total healthcare costs in the network, a percentage of healthcare costs in the network. However, the computation of the number of participants in the system or total healthcare costs in the network would involve simply tracing the data within a network and applying appropriate mathematical operations. Further, any person skilled in the art of this invention having the benefit of the disclosure of the specification would know how to calculate the percentage of participants using a network or the percentage of healthcare costs in the network from this traced information. It is therefore respectfully requested that this rejection be withdrawn.

Claims 1-4 were also rejected under 35 U.S.C. § 112 as failing to comply with the enablement requirement based on the lack of adequate disclose in the specification of how a virtual PPO network is formed. The specifications state, however, that:

> "Based upon the utilization of disruption data and projected future savings, one managed care network is selected per state. The various managed care networks selected for each state comprise a virtual health care network for providing health care services to plan sponsors, such as employer groups with employees in multiple states."

This specification discloses how the virtual PPO network is formed so as to enable one of ordinary skill in the art to make and use the invention. Thus, it is respectfully requested that this rejection be withdrawn.

Issues under 35 U.S.C. § 112

Claims 1-4 and 9-11 are rejected under 35 U.S.C. § 112 as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

Claim 1 was rejected for indefiniteness because "it is unclear how the comparing step is performed if one network is provided in the state." Claim 1 was additionally rejected because it was unclear on lines 14-16, 19-22 "how the steps for comparing and selecting are carried out if one network is provided in the preceding step for providing." Because the providing step now requires a "plurality of health care networks," the comparing and selecting steps will involve more than one network. Therefore, these rejections should be withdrawn.

Claim 1 was also rejected because it failed to recite a linkage between the "subset" and "the projected future health care savings" in the second "selecting" step. Claim 1 has been amended in a manner that is believed to render this rejection moot. Therefore, it is respectfully requested that this rejection be withdrawn.

Claim 1 was rejected because "the highest projected savings" lacked clear antecedent basis in the second "selecting" step. Claim 1 has been amended to remove this issue. It is respectfully requested that these rejections be withdrawn.

Claim 9 was rejected for being unclear as to the limitation "for each of the subset" when only one subset of networks was identified. Additionally, claim 9 was rejected because "the network" on line 12 lacked proper antecedent basis. Claim 9 has been amended to remedy this rejection.

Claim 9 was also rejected because "the greatest future savings" lacked antecedent basis. Claim 9 has now been amended to remedy this issue. Thus, it is respectfully requested that this

rejection be withdrawn.

Claim 9 was rejected because it recited a method for designing a virtual network but did not recite any step for designing a virtual network in the body of the claim. It has been amended to recite a computer-assisted method of "creating" a virtual network, thus this rejection should be withdrawn.

Because claims 2-4 and 10-11 depend on claims 1 and 9, these rejections should also be withdrawn.

Issues under 35 U.S.C. § 103

Claims 1-4 have been rejected under 35 U.S.C. § 103(a) as being unpatentable over U.S. Patent No. 5,845,254 to Lockwood et al in view of U.S. 2002/0123905 A1 to Goodroe et al and further in view of "For Health Benefits, Point and Click" by Bill Leonard (Hereinafter "Leonard"). These rejections are respectfully traversed.

Lockwood provides a method and apparatus for objectively monitoring and assessing the performance of health care providers (Abstract). Specifically, Lockwood monitors the performance of each health care provider from a group of health care providers by assessing the complexity of the health care services given by each provider. In Lockwood, claim records from physicians are analyzed in order to create severity-adjusted records for each type of sickness. After arranging providers together in groups by the severity-adjusted records, a cost-efficiency performance level is determined for each individual provider along with a qualitative performance level for the group.

With respect to the Examiner's rejections of claims 1-4, it is not clear how the prior art discloses the claimed invention from the references cited by the Examiner. In conjunction with

this response, Applicant respectfully requests that Examiner clarify the foundation for the rejections in order to properly understand and respond to said rejections. Additionally, it appears that Examiner is again equating a "health care network" as defined by the Applicant of claim 1 with an individual health care provider. It is asked that Examiner render clarification as to this consideration in light of claim 1's requirement that a health care network be formed by a "plurality of health care providers."

Claim 1 has been amended. Claim 1 now requires "providing a plurality of health care networks in each of the states for analysis wherein each of the health care networks comprises a plurality of health care providers." Lockwood's mere disclosure of the existence of a health care network does not make known the use of multiple health care networks to provide a method of creating a virtual health care provider system.

The Examiner also indicates that claim 1's limitation of "computing a measure of network utilization for each of the networks using a computer" is disclosed by Lockwood. Lockwood merely discloses the use of measurements in "monitoring the quality of health care delivered...by the network," but does not disclose the limitation of actual computation of measurements (Lockwood, Col 4, Lines 40-46). Additionally, claim 1 has been amended to include "computing measures of network utilization for each of the plurality of health care networks, using a computer wherein the measures of network utilization comprise number of participants who utilize health care providers in the network, a measure of a percentage of participants who utilize the health care providers in the network, a measure of total health care costs in the network, and a measure of a percentage of health care costs in the network." Thus, claim 1 now requires that each of these utilization measures be computed. This limitation is simply not disclosed by Lockwood, and therefore it is respectfully requested that the rejection of this limitation be

withdrawn.

The Examiner indicates that Lockwood Col. 14, lines 18-65 teaches "selecting one or more health care networks per state having the highest projected savings from the subset of the health care networks for each state, the selected one or more health care networks per state forming a smaller set that the subset of health care networks." Although claim 1 has been amended to require "selecting one or more health care networks for each state based on the measures of network utilization to provide a reduced number of health care networks for each state", neither limitation is disclosed by Lockwood.

Lockwood Col. 14, lines 18-65 merely states:

> Referring now to Fig 9, there is shown a flow diagram illustrating the operation of main step 320 and showing a system for determining severity comparison benchmarks that are used for assessing the relative performance of individual health-care providers within a group of health-care providers in accordance with a preferred embodiment of the present invention. In step 322, a common procedure or service performed by multiple health-care providers in the network for patients is selected for analysis. When sub-system 300 is used in conjunction with the budget monitoring sub-system (steps 210-240) of system 200, the common procedure or service may correspond, for example, to the procedure typically used for treating the condition selected in step 210. In step 324, each sickness episode data record in database 50 is scanned and each sickness episode data record which includes a procedure code showing that the selected common procedure was performed during the sickness episode by any health-care provider in the network is selected. In step 326, a plurality of complexity ranges are determined for the selected common procedure by analyzing the severity scores associated with the sickness episodes data records selected in step 324. In one embodiment, the severity scores associated with the selected sickness episodes are arranged in ascending order and the list is then divided at its midpoint into a first group of less severe severity scores and a second group of more severe severity scores. In step 328, a severity comparison benchmark is determined for each of the complexity ranges determined in step 326. Thus, in the embodiment discussed above, a first severity comparison benchmark is determined from the first group of less severe severity scores and a second severity comparison benchmark is determined from the second group of more severe severity scores determined in step 326. The first severity comparison benchmark is preferably determined by either averaging or taking the statistical median of the first group of less severe severity scores, and the second severity comparison benchmark is preferably determined by either averaging or taking the statistical median of the second group of more severe severity scores. It will be understood by those skilled in the art that the severity scores selected in step 324 may

divided into more than two complexity ranges, and that statistical techniques other than averaging or median selection may be used to determine severity comparison benchmarks from such complexity ranges. The process of determining severity comparison benchmarks may be repeated (as shown by block 330) on a procedure-by-procedure basis for each procedure or service performed by health-care providers in the network.

It is respectfully submitted that Lockwood does not disclose the selection of a reduced set of health care networks based on the savings of a health care network. Additionally, claim 1 selects entire health care networks based on projected savings, whereas Lockwood assesses the relative performance of individual health care providers within a group of health care providers. For these reasons, it is respectfully requested that this rejection be withdrawn.

The Examiner further rejects claim 1 based in part on Goodroe. Goodroe involves a healthcare management system which tracks supplies and materials used in clinical procedures to provide information about the resources needed for procedures and associated costs. The Examiner indicates that Goodroe discloses "the method having comparing the measures of network utilization for the health care networks in the same state." Yet Goodroe discloses the comparison of one medical facility and one doctor from another, not the comparison of related networks with a plurality of providers.

The Examiner also indicates the claim 1 limitation of "selecting one or more health care networks for each state based on the measures of utilization to provide a subset of health care networks for each state" is disclosed by Goodroe. Goodroe incorporates measuring clinical data in order to provide information about the improvements of each facility to distinguish different facilities. However, the claimed invention is not aimed at distinguishing medical facilities in order to create benchmarks for later review, but at a selection and weeding-out process of health care networks. Claim 1 has now been amended to include "selecting one or more health care

networks for each state based on the measures of network utilization to provide a reduced number of health care networks for each state, in order to clarify this distinction. Thus, it is respectfully requested that this rejection be withdrawn.

Claim 1 was further rejected based in part on Leonard. Leonard is an article which discusses the advantages and disadvantages of creating health benefit websites. The Examiner indicates that Leonard, Page 1, Paragraph 1-3 discloses "the method having a computer-assisted method of creating a virtual health care network that spans multiple states and seeks to maximize health care savings while minimizing the inconvenience to participants in changing health care providers." Yet, Leonard, Page 1, Paragraph 1-3 merely states:

> "Online technology is radically transforming the way that we conduct business, and the health care system is now in the middle of the information revolution. While traffic to health information sites is growing, e-commerce entrepreneurs are now examining ways to alter the health services market--going beyond providing information and into creating full-service health benefits web sites.
>
> These entrepreneurs are creating virtual preferred provider organizations (PPOs) or health maintenance organizations (HMOs), providing services from procuring health insurance to locating health care providers to administering claims. By delivering these services online, these companies can build large customer bases quickly and develop benefits offerings unique to the online environment.
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> 'In this intensely competitive job market, employers know that they cannot drop or severely limit the benefits they provide', says Connie Rank-Smith, SPHR, vice president of human resources for Jewelers Mutual Insurance in Neenah, Wis. "So they are searching for ways to offer benefits more efficiently and at a lower cost to their employees. And the Internet is providing some interesting options here."

Leonard does not suggest a method of how to create a virtual health care network which seeks to maximize health care savings while minimizing the inconvenience to participants in changing health care providers. Therefore, it is respectfully requested that this rejection be withdrawn.

Leonard also does not disclose "forming a virtual health care network from the selected

networks to thereby maximize health care savings while minimizing inconvenience to participants in changing healthcare providers for participants in the virtual health care network." In Leonard, a virtual PPO is created using a risk-adjusted plan that collects benefit information to be stored in a virtual environment. If a provider is within the virtual PPO system, a risk factor will be calculated for the provider to show the insurance risks associated with using that provider. This calculated risk is then stored in an online system and can be used by insurance companies who are insuring those individual providers. Thus, Leonard's virtual PPO includes keeping up-to-date records about benefits and risks of individual providers so that insurance companies can better assess a provider's policy. This virtual PPO is completely different than the virtual health care network of the present invention, and thus this rejection should be withdrawn. As claims 2-8 depend from claim 1, it is respectfully submitted that these rejections be withdrawn as well.

There is an independent reason for the patentability of claim 2. Claim 2 was rejected on the basis that Lockwood discloses "the method wherein the future health care savings are projected based upon historical health care costs for participants, health care network discounts and a portion of the historical health care costs projected to fall to a health care provider in the network." Lockwood, however, merely discloses the use of standard benchmarks for different procedures in order to evaluate and monitor costs of particular claims. Lockwood does not disclose the limitation of "projecting" future health care savings based on those benchmarks. Therefore, it is respectfully requested that this rejection be withdrawn.

Claims 9-11 have been rejected under 35 U.S.C. § 103(a) as being unpatentable over U.S. Patent No. 5,845,254 to Lockwood et al in view of U.S. 2002/0123905 A1 to Goodroe et al.

The Examiner indicates that Lockwood discloses the limitation "for each of the group

health care networks, collecting information concerning the number of potential plan participants who utilize a health care provider under the networks." Lockwood, however, merely discloses the monitoring of health care budgetary limits and complexity levels of provider case-loads, not the number of potential plan participants. It is thus respectfully requested that this rejection be withdrawn on this basis.

The Examiner also indicates that Lockwood discloses the limitation of "determining utilization for each of the networks based upon the number of potential plan participants who utilize a health care provider under the networks." Claim 1 was rejected for a similar limitation, and the explanations for the withdrawal of claim 1's rejection are incorporated herein. Thus, it is respectfully requested that this rejection be withdrawn as well.

Claim 9 was rejected based on Goodroe's disclosure of "the method having comparing the utilization for the networks" and "identifying a subset of the networks with the highest utilization, the subset of the networks less than a total number of networks." Claim 9 has been amended to include "determining utilization for each of the networks in the plurality of networks based upon the number of potential plan participants who utilize a health care provider under the networks." Thus, it is respectfully requested that these rejections be withdrawn.

The Examiner also indicates that Goodroe discloses "selecting one or more of the networks having the greatest future savings." Goodroe merely discloses the method of obtaining the amount of potential savings from two different providers for a certain procedure. Goodroe does not involve selecting an entire network based on a network's future savings. Therefore, it is respectfully requested that this rejection be withdrawn on this basis as well. As claims 10-11 depend from claim 9, it is respectfully submitted that these rejections also be withdrawn.

It is respectfully submitted that with respect to all pending claims, the Examiner fails to

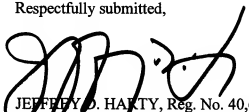
provide any convincing line of reasoning for the rejections or combining the rejections. None of the references cited by the Examiner incorporate using a virtual health care network to minimize inconvenience to participants while changing health care providers.

Conclusion

Therefore, as the Examiner has failed to establish a *prima facie* case of obviousness with respect to each claim, these rejections must be withdrawn and the Examine should find all claims allowable.

No fees or extensions of time are believed to be due in connection with this amendment; however, consider this a request for any extension inadvertently omitted, and charge any additional fees to Deposit Account No. 26-0084.

Respectfully submitted,



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